

2004

Medical Plan

Summary

Department of Administration • State Personnel Division • Room 125 • Mitchell Building

PO Box 200127 • Helena MT • 59620-0127

1-800-287-8266 or 444-7462 in Helena

www.state.mt.us/doa/spd/benefits/healthbenefits.asp

ANNUAL BENEFIT PLAN SUMMARY

MEDICAL PLAN



Blue Cross/Blue Shield of Montana • 1-800-423-0805 or 444-8315
www.bluecrossmontana.com

New West Health Plan • 1-800-290-3657 or 457-2202
www.newwesthealth.com

Peak Health Plan • 1-866-368-7325
www.healthinfontmt.com

MEDICAL RATES

Monthly Premiums	Traditional	Peak	Blue Choice	New West
Employee	\$365	\$357	\$352	\$328
Employee & spouse	\$532	\$524	\$509	\$487
Employee & children	\$486	\$480	\$466	\$447
Employee & family	\$560	\$551	\$535	\$511
Joint Core	\$420	\$418	\$404	\$390

MEDICAL PLAN COSTS

Annual Deductible*

(Applies to all services, unless otherwise noted)

Coinsurance Percentages

General

Preferred Facility Services *(See page 33 for a list of preferred facilities)*

Nonpreferred Facility Services *(See page 33 for a list of non-preferred facilities)*

Annual Out-of-Pocket Maximums*

(Maximum coinsurance paid in the year; excludes deductibles and copayments)

*You pay deductible and coinsurance on allowable charges only (see Glossary on page 4).

MEDICAL PLAN SERVICES

Hospital Services

(Inpatient services must be certified. Pre-certification is strongly recommended.)

Room Charges

Ancillary Services

Surgical Services

Outpatient Services

BENEFIT YEAR 2004

MEDICAL LIFETIME MAXIMUMS

Each Plan has a set maximum payable. This maximum is per person, per lifetime. The amounts shown below are the amounts that the plan would pay on an individual.

Traditional Plan: \$1,000,000 lifetime maximum; Additional \$2,000 available annually after the lifetime maximum is met.

Managed Care Plans: \$1,000,000 lifetime maximum

MANAGED CARE BENEFIT PLANS		
BLUE CHOICE - Administered by Blue Cross/Blue Shield of MT NEW WEST - Administered by New West Health Plan PEAK - Administered by Peak Health Plan		
Administered by BCBS and APS	In-Network Benefits	Out-of-Network Benefits
\$550/Member \$1,650/Family	\$400/Member \$800/Family	Separate \$500/Member Separate \$1,000/Family
25% 20% 35%	25%	35%
Average of \$2,500/Member <i>(20% - 35% of \$10,000 in allowable charges)</i> Average of \$5,000/Family <i>(20% - 35% of \$20,000 in allowable charges)</i>	\$2,000/Member \$4,000/Family	Separate \$2,000/Member Separate \$4,000/Family
Coinsurance:	Coinsurance/Copayment:	Coinsurance:
20% - 35%	25%	35%
20% - 35%	25%	35%
20% - 35%	25%	35%
20% - 35%	25%	35%
20% - 35%	25%	35%

ANNUAL BENEFIT PLAN SUMMARY

MEDICAL PLAN COSTS

Physician Services

Office Visits

Inpatient Physician Services

Lab/Ancillary/Miscellaneous Charges

Emergency Services

Ambulance Services for Medical Emergency

Emergency Room
Hospital Charges

Professional Charges

Urgent Care Facility Services - Hospital Based
Hospital Charges

Urgent Care Facility Services - Free Standing
Facility Services

Maternity Services

Hospital Charges

Physician Charges

Prenatal Office Visits

Routine Newborn Care
Inpatient Hospital Charges

Preventive Services

Adult Exams and Tests

Mammogram, gyno exam and pap, proctoscopic
and colonoscopic exams, PSA tests, bone density tests

Adult Immunizations for Pneumonia and Flu

Well-Child Checkups and Immunizations

Mental Health Services

Mental Health Care

Inpatient Services

(Inpatient services must be certified. Pre-certification is strongly recommended.)

Max: One inpatient day may be exchanged for two partial hospital days.

Outpatient Services

With required referral or EAP counselor referral

With NO required referral or EAP counselor referral

BENEFIT YEAR 2004

TRADITIONAL PLAN	IN-NETWORK MANAGED CARE	OUT-OF-NETWORK MANAGED CARE
25% (no deductible for first two non-routine office visits)	\$15/visit (some lab & diagnostic included)	35%
25%	25%	35%
25%	25%	35%
25%	\$100 copay	Covered under In-Network Benefit
20% - 35%	\$75/visit for facility charges only (waived if inpatient hospital or out-patient surgery coinsurance applies)	Covered under In-Network Benefit
25%	25%	25%
20% - 35%	\$25/visit	\$25/visit
25%	\$25/visit	\$25/visit
20% - 35%	25%	35%
25%	25%	35%
25%	\$50 global copay for all prenatal care	35%
20% - 35% (no deductible)	25%	35%
25% (no deductible) Max: 2 bone density tests/lifetime Max: \$250 for colonoscopy or sigmoidoscopy	\$15/visit (periodic physicals covered, including PSA, PAP, basic blood panel, and limited lab work) \$0 co-pay for mammogram 25% for bone density scan, sigmoidoscopy, colonoscopy, proctoscopy	35%
Not covered	\$15 with office visit (Allergy shots 25%, with no deductible in-network)	35%
0% (25% (no deductible) no deductible for County Health Department) (through age 5)	\$15/visit Max: Academy of Pediatrics Definitions (through age 18)	35%
20% - 35% 21 days (No max for severe conditions)	25% 21 days (No max for severe conditions)	35%
25% Max: 40 visits (No max for severe conditions)	\$15/visit Max: 30 visits (No max for severe conditions)	35%
50% Max: 20 visits (No max for severe conditions)	\$15/visit Max: 30 visits (No max for severe conditions)	35%

ANNUAL BENEFIT PLAN SUMMARY

MEDICAL PLAN COSTS

Chemical Dependency

Inpatient Services*

(Inpatient services must be certified. Pre-certification is strongly recommended.)

Outpatient Services*

With required referral or EAP counselor referral

With NO required referral or EAP counselor referral

*Dollar Limit Max for all Chemical Dependency Services: Combined inpatient/outpatient max of \$6,000/year; \$12,000/lifetime; \$2,000/year thereafter.

Rehabilitative Services

Physical, Occupational, and Speech Therapy

Inpatient Services

(Inpatient services must be certified. Pre-certification is strongly recommended.)

Outpatient Services – Hospital

Outpatient Services – Non-Hospital

Alternative Health Care Services

Acupuncture

Naturopathic

Chiropractic

Extended Care Services

Home Health Care

(Physician ordered/prior authorization recommended)

Hospice

Skilled Nursing

Miscellaneous Services

Dietary/Nutritional Counseling

(When medically necessary and physician ordered)

Durable Medical Equipment, Appliances, and Orthotics

(Prior authorization required for amounts over \$500)

PKU Supplies

Transportation *(Limited to reasonable one-way expenses for services not available in MT)*

Organ Transplants

(Must be certified. Pre-certification is strongly recommended.)

Transplant Services

Lifetime Maximums:

BENEFIT YEAR 2004

TRADITIONAL PLAN	IN-NETWORK MANAGED CARE	OUT-OF-NETWORK MANAGED CARE
20% - 35%	25%	35%
25% Max: 40 visits and Dollar Limit*	\$15/visit Max: Dollar Limit*	35%
50% Max: 20 visits and Dollar Limit*	\$15/visit Max: Dollar Limit*	35%
20% - 35% Max: 60 days	25% Max: 60 days	35% Max: 60 days
20% - 35% Max: \$2,000/year for all outpatient (\$10,000/year for prior-auth. conditions)	\$15/visit Max: 30 visits	35% Max: 30 visits
25% Max: \$2,000/year for all outpatient (\$10,000/year for prior-auth. conditions)	\$15/visit Max: 30 visits	35%
25% (plus charges over \$30/visit)	Not covered	Not covered
25% (plus charges over \$30/visit)	Not covered	Not covered
25% (plus charges over \$30/visit) Max: 25 visits in any combination for alternative health care	\$15/visit Max: 20 visits for chiropractic subject to required referral	Not covered
25% Max: 70 days	\$15/visit Max: 30 visits	35% Max: 30 visits
25% (20% - 35% if hospital-based) Max: 6 months	25% Max: 6 months	35% Max: 6 months
25% (20% - 35% if hospital-based) Max: 70 days	25% Max: 30 days instead of hospitalization	35% Max: 30 days instead of hospitalization
20% - 35% Max: \$250	\$15/visit Max: no limit	35%
25% Max: \$100 for foot orthotics (per foot)	25% (Not applied to out-of-pocket max) Max: \$100 for foot orthotics (per foot)	35%
25%	0% (Plan pays for 100% for services required under State mandate.)	35%
25%	Ambulance service & organ transplant only	Not covered
25% <ul style="list-style-type: none"> • Liver: \$200,000 • Heart: \$120,000 • Lung: \$160,000 • Heart/Lung: \$160,000 • Bone Marrow: \$160,000 • Pancreas: \$68,000 • Cornea/Kidney: No maximum 	25% \$500,000 lifetime maximum with \$5,000 of the maximum available for travel to and from the facility.	Not covered